Medicaid Reform Whole Person Integration Workgroup - Summary of Responses

Special thanks to our research team members who assisted in gathering this information.

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STATE	BENEFITS	LIMITATION	OPERATIONAL CHALLENGES	METRICS	TAKE-AWAY
Arizona 	Care coordination Case management	Not all services are under the plan State established supportive waiver program to cover attendant care outside of Managed Care Organizations (MCOs)	Inadequate provider network due to low rates Plans need to be held accountable	No Metrics	Medicaid policy staff require a different skill set to effectively administer and oversee MCO activities Consumer representation is a must, including and independent appeals process High duals population will help defray expenditures as Medicare will assume a majority of the expenses
	Whole person care, including Long Term Services and Support (LTSS) and behavioral health for the Age, Blind, and Disabled (ABD)		Some services have been chipped away in a down-turn economy Managing duals and Medicare is a challenge	No Metrics	Establish a plan to deal with duals

Florida	Care coordination 	Waiting lists for Home and Community Based Services (HCBS) MCOs have all the power and are highly connected to the political process Providers have lost their negotiating power	Inadequate provider network Providers who complain get "shut out" Low rates	No Metrics	Ensure a medical loss ratio is included in the MCO contract Prioritize home and community based services
	Case management	Plans have inadequate knowledge of LTSS IDD population is carved out	No standardized policies and procedures, increasing provider costs Payment delays Beneficiaries may switch plans at will causing administrative burden	MCO contract metrics, such as timely payment, but no quality metrics	Case management is a benefit as long as plans understand the various programs Improve communications between MCOs, physicians, care coordinators, and providers/supplies to ensure timely and medically appropriate services
	Case management Consumer choice	Limits HCBS slots Plans have an inadequate knowledge Providers have lost their negotiating power Brokers enroll recipients	Model is designed to reward MCOs financially for reducing expenditures, but not for improving quality Payments delays	Consumer Assessment Healthcare Provider System (CAHPS) Patient Satisfaction	Establish parameters to ensure value (access, quality, and cost)

Kansas	Elimination of waiting list (it is unclear whether everyone received care, they all got assessed) All LTSS under managed care	Inadequate provider network No standardization among MCOs - Differences in requirements and terminology makes it confusing	Out of state companies severed case management relationships Payment delays Fear of retaliation by MCOs	Metrics are focused on contractual obligations rather than on the health and wellbeing of the recipient	Going cold-turkey produces a lot of challenges for recipient and providers 
Ohio 	Phasing in the managed care implementation	MCOs don't understand supportive services	Backlog Payment delays No standardization of policy and procedures among plans	HEDIS Measures	Ensure MCOs have knowledge and experience in LTSS Look at integrating other state programs, like aging housing subsidies and caregiver support in order to maintain independence at home
Minnesota	Case management Community transition plans Expansion of HCBS Investment in HCBS Declining use of NH beds (while NH don't see that as a benefit)		Rate Cuts Reduction in hours	No Metrics	Community transition plans Success is attributed to the strong leadership from a series of DHS commissioners and Division directors Investment in HCBS Incentives to purchase LTC insurance
	Requires specialized	While specialized	Transition to managed	No Metrics	Specialize staff training

	training of staff caring for medically fragile	training for nurses caring for medically fragile ensures competency, the certification / re-certification progress can be cumbersome	Medicaid has had a negative impact on clients: severely limiting supplies and requiring co-pays Delays in assessments causes delays in access		requirements should be relevant with a straight forward certification process
Tennessee	State-wide MCOs 	No standardization among MCOs Inadequate provider network, with rates not covering the costs Differences in requirement and terminology makes it confusing No benefits to consumers or providers while MCO's profits are in the hundreds of millions	Delays in payments, high receivables Minor claim errors result in denials MCOs not fully understanding hospice	HEDIS Measures Patient Satisfaction	Inadequate provider network results in longer hospitalization stays Establish parameters for percent of funds paid for services
Texas	Coordination of care MCOs may use "value-added services" to keep recipients in a lower cost setting	Not all settings are included (institutions are out) MCOs want a one-size fits all approach to metrics	MCOs don't understand IDD population and require "clinical edits' to receive services Lack of medication (psychotropic) can lead to institutionalization	No metrics MCO want to use acute care measures on an IDD population	Person-centered planning should address the uniqueness of the recipient Deploy "value-added services" to keep recipients Institute systems and

			While the legislature talks about reducing waitlist, IDD recipients haven't seen a reduction Lack of objectivity by some of the case workers Administrative burden in service delivery		processes that requires accountability of MCO
	Case management	Providers are left to find solutions on their own for their clients	Coordination amongst the various providers is laborious and often not timely Negotiating contract with MCOs is difficult	No Metrics	Coordination of care among the various provider types will decrease costs and improve quality
Wisconsin	Elimination of waitlist Option to self-direct Care coordination	Plans focus on acute care medical model, rather than chronic long-term support Gaps in provider availability and quality Medicaid doesn't reward MCO best practice, nor does it penalize poor preforming MCOs	Rate cuts Reductions in services 	No Metrics	Invest in practices that prevents the erosion of the provider network through incentives that reward quality, advances best practices across the network, and provides corrective feedback to poor performers
	Expansion of Family Care option to 7 counties	Limited provider network, especially for medically complex	Low rates Capitated monthly rate will not support medically complex cases at home	No Metrics	Person-centered planning should address the uniqueness of the recipient